Appendix C

Consent/Waiver Forms

ATTACHMENT A

Consent & Waiver Forms

(Note: Waiver and Consent for Persons under the age of 18)

INTERAGENCY COLLABORATION AND SERVICES INTEGRATION COMMISSION (ICSIC COMMISSION)

PARENT/GUARDIAN CONSENT FOR ASSESSMENT AND TREATMENT AND WAIVER OF CONFIDENTIALITY

WHAT IS THE INTERAGENCY COLLABORATION AND SERVICES INTEGRATION COMMISSION (ICSIC)?

ICSIC (or "the Commission") is comprised of District agencies and public leaders concerned with the welfare of children and families. It does not provide services. The Commission is dedicated to promoting the healthy development of children and youth in the community -- academically, socially, emotionally, and physically. Member agencies of this Commission will work together to make sure that there are more high quality programs and services available to reduce juvenile and family violence, to promote educational success, and to address mental health and substance abuse problems before they become serious and hard to resolve.

The Commission is working to ensure that children and youth who are at-risk receive thorough and complete assessments of their needs and strengths. These assessments are being conducted by qualified, professional clinicians based in schools. The Commission is also simplifying the process by which children at risk and their families get help. Once they have conducted the assessment, the clinician will form a plan of services that, depending on the strengths and needs, may involve several agencies. This plan will be specifically designed to meet the needs of a particular child's and family's needs.

MEMBERS OF THE ICSIC COMMISSION

The following agencies make up the Interagency Collaboration and Services Integration Commission of Washington, D.C.:

- Mayor of the District of Columbia, who is Chair of the Commission;
- Chairman of the Council of the District of Columbia;
- Chair of the Committee on Human Services;
- Chief Judge, Family Court, Superior Court of the District of Columbia;
- Deputy Mayor for Education;
- City Administrator;
- State Superintendent of Education;
- Chancellor of the District of Columbia Public Schools;
- Chair of the Public Charter School Board;
- Director of the Department of Human Services;
- Director of the Child and Family Services Agency;
- Director of the Department of Youth Rehabilitation Services;
- Director of the Department of Corrections;
- Director of the Department of Health;
- Director of the Department of Mental Health;
- Chief of the Metropolitan Police Department;
- Director of the Court Social Services Agency;
- Attorney General for the District of Columbia;
- Director of the Criminal Justice Coordinating Council;
- Director of the Department of Parks and Recreation;
- Director of the District of Columbia Public Library.

WHAT CAN THE COMMISSION DO FOR ME AND MY FAMILY?

Children often have complicated problems that can interfere with their ability to reach their full potential. These problems can come from many sources – family, school, community, and children themselves. Solutions can, and often do, come from many sources. It is often difficult for families seeking solutions to navigate among the many agencies where they can find help.

The ICSIC Commission is designed to assist families in obtaining help for their children as problems are developing without having to go to several agencies. By providing a way for the agencies to work together, the Commission helps families get to the correct resources quickly, before problems become more serious. The Commission does not provide services itself. Instead, Commission member agencies work together to ensure that high quality assessment and services are provided to families.

You are being asked to sign this Consent and Waiver form by a school-based clinician. When the form is signed, the clinician will be able to fully assess your child's needs and develop the best possible service plan. To do so, the clinician must be able to fully understand the kinds of help that will best serve your family. We are asking your permission to speak with you, your child, and other family/household members. We also are asking for your permission to collect information from service agencies. Once needs are assessed, the clinician will work with you and your family members to write a plan for addressing the problems. You will be a part of both the assessment and treatment plan, and no services will be provided unless you agree.

All the Commission agencies are committed to protecting all of your rights under federal and District of Columbia laws, including your rights to notice, privacy, and confidentiality.

We are asking you to sign this form, which will allow any of the ICSIC Commission members listed above, and any agency or individual listed below which you may add to this form, to provide the necessary information for assessment, planning, and treatment. All this information will be carefully protected by the Commission to preserve your confidentiality. If you do not agree to permit the school-based clinician to collect information from services agencies, it will be more difficult to fully assess your child's needs, to develop the best possible service plan, and to provide services in the most effective manner possible.

WHAT WILL ICSIC DO WITH INFORMATION IT RECEIVES?

The school-based clinician explaining this Consent and Waiver will use the information in the assessment to develop with you the best possible plan of services for your child and family. The clinician must keep your information confidential. This Consent and Waiver form generally does not allow the clinician to share information gathered with anyone without your permission. Information gathered by the clinician may not be provided to law enforcement authorities without a court order. Further, the information gathered by the clinician is not subject to Freedom of Information Act ("FOIA") requests served upon the government and will not be disclosed to the public.

The clinician may share information with other ICSIC Commission staff or with a supervisor or another clinician to consult with them to make sure you have the highest quality of services and to ensure that any information obtained is properly stored and protected. These other professionals must also maintain your confidentiality.

PARENT/GUARDIAN CONSENT AND WAIVER

Name of parent/guardian: _____
Date of birth: _____
Address: _____
Telephone: _____

Name of parent/guardian: _____
Date of birth: _____
Address: _____
Telephone: _____

Name of child of parent/guardian signing this form: _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of child of parent/guardian signing this form: _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of child of parent/guardian signing this form: _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of other adult in the household (18 and over): _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Note to clinician: Please add additional names of persons subject to this Consent and Waiver as necessary.

NOTE: The person or persons providing consent may cross out any sections that do not apply. This Consent and Waiver may apply to one or more children.

1) I hereby give consent to the school-based clinician who is working with the ICSIC Commission to assess my child, to develop a coordinated plan of services for my child and family, and to provide or arrange for treatment for my child, if appropriate.

Initials of Persons signing the Consent & Waiver form: _____

Information regarding my child:

2) I hereby consent to the collection of information about my child for the purposes of assessment, planning, and treatment. I understand that the clinician may assess my child, form a plan of services for my child and family, and provide treatment for my child, if appropriate. Information may be requested from the agencies and organizations that are members of the ICSIC Commission, and from other sources as I may list separately.

3) I understand that the members of the ICSIC Commission include:

- Mayor of the District of Columbia;
- Chairman of the Council of the District of Columbia;
- Chair of the Committee on Human Services;
- Chief Judge, Family Court, Superior Court of the District of Columbia;
- Deputy Mayor for Education;
- City Administrator;
- State Superintendent of Education;
- Chancellor of the District of Columbia Public Schools;
- Chair of the Public Charter School Board;
- Director of the Department of Human Services;
- Director of the Child and Family Services Agency;
- Director of the Department of Youth Rehabilitation Services;
- Director of the Department of Corrections;
- Director of the Department of Health;
- Director of the Department of Mental Health;
- Chief of the Metropolitan Police Department;
- Director of the Court Social Services Agency;
- Attorney General for the District of Columbia;
- Director of the Criminal Justice Coordinating Council;
- Director of the Department of Parks and Recreation;
- Director of the District of Columbia Public Library.

Information regarding myself and my other family members:

4) I also agree that the school-based clinician may obtain confidential information about me and other persons listed above from the agencies and organizations that are members of ICSIC Commission, and from other sources as I may list below.

5) I understand that it is the intention of ICSIC Commission that I may participate in the assessment and case planning process if I choose and that I may invite a support person or advocate to attend meetings with me.

6) I understand that this Consent and Waiver remains in effect until the following date _____ and that I may choose to renew it.

*Initials of Persons signing the Consent & Waiver form:*_____

7) The clinician may collect mental health information for only 60 days after this Consent and Waiver is signed. I understand that I have the right to see the mental health record for which I am granting access to the clinician. I understand that a copy of this Consent and Waiver form shall be included with the mental health record.

8) I understand I may ask any questions or make any comments about this Consent and Waiver. **I also understand that I may cancel this Consent and Waiver at any time by contacting the ICSIC Commission office in writing at the following address:**

Consent and Waivers
Interagency Collaboration and Services Integration Commission (ICSIC)
(TBD)
(TBD)
Washington, D.C.

ICSIC Commission staff will mail the cancellation notice to all agencies or individuals who have received this Consent and Waiver.

9) I understand that, if I cancel this Consent and Waiver, any disclosures made before I cancelled this consent are not violations of confidentiality.

10) I understand that neither the signing nor the canceling of this Consent and Waiver restricts the obligation of any person to disclose information if required to do so by law.

11) I understand that information disclosed according to this Consent and Waiver will be kept confidential by the school-based clinician. It will not be redisclosed to any other person, agency or organization, including ICSIC Commission agencies, without my additional consent in writing except, as noted above, for case consultation, supervision, and administrative purposes.

11) I understand that I am not required to consent to the disclosure of any information, to give permission to the school-based clinician working with the ICSIC Commission to assess or develop a case plan for my child, or to accept any treatment. The specific types of information that I agree the clinician may obtain are listed at the end of this form. I also understand that I may discontinue involvement at any time.

12) I understand that this Consent and Waiver means that the agencies or individuals covered by this consent will release information to the school-based clinician based on their opinion that the information is relevant. As a result, my consent may not result in the release of all information maintained by an agency or individual.

13) The school-based clinician working with the ICSIC Commission has reviewed this form with me, explained its purpose, answered any questions I had. I have also been offered the opportunity to have this form in another language or read

*Initials of Persons signing the Consent & Waiver form:*_____

to me. The clinician has also informed me that I may choose a person to assist me with this Consent and Waiver form.

14) By signing this document, I confirm that I am the parent or legal guardian of the child who is the subject of this Consent and Waiver form.

15) If my child is between the ages of 14 and 18, I understand that my child who is the subject of this Consent and Waiver must also sign the form.

Parent's/guardian's signature	Child's signature if 14 years or over
Date:_____	Date: _____
Printed Name of clinician explaining form	Printed Name of clinician explaining form
Signature of clinician explaining the form	Signature of clinician explaining the form
Parent's/guardian's signature	Child's signature if 14 years or over
Date:_____	Date: _____
Printed Name of clinician explaining form	Printed Name of clinician explaining form
Signature of clinician explaining the form	Signature of clinician explaining the form

Additional signatures of persons who are subject to this Consent and Waiver:

Parent's/guardian's signature	Child's signature if 14 years or over
Date: _____	Date:_____
Printed Name of clinician explaining form	Printed Name of clinician explaining form
Signature of clinician explaining the form	Signature of clinician explaining the form

Signature of other adult in the household

Date: _____

Printed Name of clinician explaining form

Signature of clinician explaining the form

Signature of other adult in the household

Date: _____

Printed Name of clinician explaining form

Signature of clinician explaining the form

OTHER SOURCES OF INFORMATION

In addition to the member agencies of ICSIC Commission who will be providing information regarding my child, I also consent to the release of information by the following agencies and individuals:

Name of Agency/Individual	Name of Agency/Individual
Address/Telephone Number	Address/Telephone Number
Parent's/guardian's signature	Parent's/guardian's signature
Child's signature if 14 years or over	Child's signature if 14 years or over
Date:	Date:
Witness:	Witness:

Name of Agency/Individual	Name of Agency/Individual
Address/Telephone Number	Address/Telephone Number
Parent's/guardian's signature	Parent's/guardian's signature
Child's signature if 14 years or over	Child's signature if 14 years or over
Date:	Date:
Witness:	Witness:

Name of Agency/Individual	Name of Agency/Individual
Address/Telephone Number	Address/Telephone Number
Other adult (over 18) in the household	Other adult (over 18) in the household
Date:_____	Date: _____
Witness: _____	Witness: _____

CONSUMER CONSENT TO DISCLOSURE OF ALCOHOLISM OR SUBSTANCE ABUSE TREATMENT INFORMATION (42 CFR Part 2)

As a child/adolescent who is the subject of this assessment, I authorize release to the school-based clinician working with the ICSIC Commission the following alcoholism and substance abuse treatment information:

Name of Alcoholism or Substance Abuse Agency: _____

Type of Information	Release (yes/no)	Obtained (yes/no)
The type of chemical use or dependence, frequency of use, duration of use		
Information concerning the intake disposition/enrollment		
My plans for treatment (e.g. short and long term goals and planned services)		
My progress and degree of participation in any alcoholism or substance abuse treatment, including related services/activities, dates, and results of urinalysis and other AOD/toxicology related tests		
Termination or completion of my treatment		

This information is provided for the purpose of allowing the school-based clinician working with the ICSIC Commission to:

_____Conduct an assessment

_____Develop and manage a treatment plan

_____Make referrals and coordinate services with other service and treatment providers

_____Develop and implement a discharge plan

_____Enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf.

I understand that the above information is protected by Federal Regulation 42 CFR, Part 2: "Confidentiality of Alcohol and Drug Abuse Patient Records" and can only be disclosed with my written consent unless otherwise provided for in the regulations. The duration of this authorization is one year, or the duration of the above Consent and Waiver, whichever is shorter. I understand that I may revoke this consent at any time by following the procedures outlined in the Consent and Waiver, above. I understand that the school-based clinician must treat the above-cited information as confidential and may share the information only as indicated in Section 10 of the Consent and Waiver.

_____ _____

Child's signature if 14 years or over (Date) Signature of Parent/Guardian (Date)

_____ _____

Signature of Clinician Explaining Form (Date) Signature of Parent/Guardian (Date)

TYPES OF INFORMATION THAT MAY BE OBTAINED BY THE CLINICIAN

Please Cross Out Any Type of Information You Do Not Want Disclosed to the Clinicians

Type of Information Obtained by the Clinician	Agency Providing the Information
This table will be completed once the appropriate information is provided by ICSIC members. At that point the Consent and Waiver form will be available for administration by school-based clinicians	
e.g mental health records, school records…	

(Note: Waiver and Consent for Persons 18 years and over)

INTERAGENCY COLLABORATION AND SERVICES INTEGRATION COMMISSION (ICSIC COMMISSION) CONSENT FOR ASSESSMENT AND TREATMENT AND WAIVER OF CONFIDENTIALITY

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The Commission is working to ensure that that children, youth, and young adults who are at-risk receive thorough and complete assessments of their needs and strengths. These assessments are being conducted by qualified, professional clinicians based in schools. The Commission is also simplifying the process by which children at risk and their families get help. Once they have conducted the assessment, the clinician will form a plan of services that, depending on the strengths and needs, may involve several agencies. This plan will be specifically designed to meet the needs of a particular child's and family's needs.

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- City Administrator;
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- Chancellor of the District of Columbia Public Schools;
- Chair of the Public Charter School Board;
- Director of the Department of Human Services;
- Director of the Child and Family Services Agency;
- Director of the Department of Youth Rehabilitation Services;
- Director of the Department of Corrections;
- Director of the Department of Health;
- Director of the Department of Mental Health;
- Chief of the Metropolitan Police Department;
- Director of the Court Social Services Agency;
- Attorney General for the District of Columbia;
- Director of the Criminal Justice Coordinating Council;
- Director of the Department of Parks and Recreation;
- Director of the District of Columbia Public Library.

WHAT CAN THE COMMISSION DO FOR ME AND MY FAMILY?

Young adults often have complicated problems that can interfere with their ability to reach their full potential. These problems can come from many sources – family, school, community, and youth themselves. Solutions can, and often do, come from many sources. It is often difficult for those seeking solutions to navigate among the many agencies where they can find help.

The ICSIC Commission is designed to assist you and your family in obtaining help to address problems that are developing without having to go to several agencies. By providing a way for the agencies to work together, the Commission helps young adults and their families get to the correct resources quickly, before problems become more serious. The Commission does not provide services itself. Instead, Commission member agencies work together to ensure that high quality assessment and services are provided.

You are being asked to sign this Consent and Waiver form by a school-based clinician. When the form is signed, the clinician will be able to fully assess your needs and develop the best possible service plan. To do so, the clinician must be able to fully understand the

kinds of help that will best serve you and your family. We are asking your permission to speak with you and other family/household members. We also are asking for your permission to collect information from service agencies. Once needs are assessed, the clinician will work with you and your family members to write a plan for addressing the problems. You will be a part of both the assessment and treatment plan, and no services will be provided unless you agree.

All the Commission agencies are committed to protecting all of your rights under federal and District of Columbia laws, including your rights to notice, privacy, and confidentiality.

We are asking you to sign this form, which will allow any of the ICSIC Commission members listed above, and any agency or individual listed below which you may add to this form, to provide the necessary information for assessment, planning, and treatment. All this information will be carefully protected by the Commission to preserve your confidentiality. If you do not agree to permit the school-based clinician to collect information from services agencies, it will be more difficult to fully assess your needs, to develop the best possible service plan, and to provide you services in the most effective manner possible.

WHAT WILL ICSIC DO WITH INFORMATION IT RECEIVES?

The school-based clinician explaining this Consent and Waiver will use the information in the assessment to develop with you the best possible plan of services for your child and family. The clinician must keep your information confidential. This Consent and Waiver form generally does not allow the clinician to share information gathered with anyone without your permission. Information gathered by the clinician may not be provided to law enforcement authorities without a court order. Further, the information gathered by the clinician is not subject to Freedom of Information Act ("FOIA") requests served upon the government and will not be disclosed to the public.

The clinician may share information with other ICSIC Commission staff or with a supervisor or another clinician to consult with them to make sure you have the highest quality of services and to ensure that any information obtained is properly stored and protected. These other professionals must also maintain your confidentiality.

CONSENT AND WAIVER

My Name: _____
Date of birth: _____
Address: _____
Telephone: _____

Name of parent/guardian/other adult in the household (18 or over): _____
Date of birth: _____
Address: _____
Telephone: _____

Name of parent/guardian/other adult in the household (18 or over): _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of parent/guardian/ other adult in the household (18 or over): _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of child of parent/guardian signing this form: _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Name of child of parent/guardian signing this form: _____
Date of birth: _____
Address: _____
Telephone: _____
School: _____

Note to clinician: Please add additional names of persons subject to this Consent and Waiver as necessary.

NOTE: The person or persons providing consent may cross out any sections that do not apply.

1) I hereby give consent to the school-based clinician who is working with the ICSIC Commission to assess me, to develop a coordinated plan of services for me and for others in my family/household if they consent, and to provide or arrange for treatment for me, if appropriate.

Initials of Persons Signing the Consent & Waiver form: _____

2) I hereby consent to the collection of information about me for the purposes of assessment, planning, and treatment. I understand that the clinician may assess me, form a plan of services for me and for others in my family/household if they consent, and provide treatment for me, if appropriate. Information may be requested from the agencies and organizations that are members of the ICSIC Commission, and from other sources as I may list separately.

3) I understand that the members of the ICSIC Commission include:

- Mayor of the District of Columbia;
- Chairman of the Council of the District of Columbia;
- Chair of the Committee on Human Services;
- Chief Judge, Family Court, Superior Court of the District of Columbia;
- Deputy Mayor for Education;
- City Administrator;
- State Superintendent of Education;
- Chancellor of the District of Columbia Public Schools;
- Chair of the Public Charter School Board;
- Director of the Department of Human Services;
- Director of the Child and Family Services Agency;
- Director of the Department of Youth Rehabilitation Services;
- Director of the Department of Corrections;
- Director of the Department of Health;
- Director of the Department of Mental Health;
- Chief of the Metropolitan Police Department;
- Director of the Court Social Services Agency;
- Attorney General for the District of Columbia;
- Director of the Criminal Justice Coordinating Council;
- Director of the Department of Parks and Recreation;
- Director of the District of Columbia Public Library.

4) I also agree that the school-based clinician may obtain confidential information about other persons listed above from the agencies and organizations that are members of ICSIC Commission, and from other sources as I may list below.

5) I understand that it is the intention of ICSIC Commission that I may participate in the assessment and case planning process if I choose and that I may invite a support person or advocate to attend meetings with me.

6) I understand that this Consent and Waiver remains in effect until the following date _____ and that I may choose to renew it.

7) The clinician may collect mental health information for only 60 days after this Consent and Waiver is signed. I understand that I have the right to see the mental health record for which I am granting access to the clinician. I

*Initials of Persons Signing the Consent & Waiver form:*_____

understand that a copy of this Consent and Waiver form shall be included with the mental health record.

8) I understand I may ask any questions or make any comments about this Consent and Waiver. **I also understand that I may cancel this Consent and Waiver at any time by contacting the ICSIC Commission office in writing at the following address:**

Consent and Waivers
Interagency Collaboration and Services Integration Commission (ICSIC)
(TBD)
(TBD)
Washington, D.C.

ICSIC Commission staff will mail the cancellation notice to all agencies or I understand that, if I cancel this Consent and Waiver, any disclosures made before I cancelled this consent are not violations of confidentiality.

9) I understand that, if I cancel this Consent and Waiver, any disclosures made before I cancelled this consent are not violations of confidentiality.

10) I understand that neither the signing nor the canceling of this Consent and Waiver restricts the obligation of any person to disclose information if required to do so by law.

11) I understand that information disclosed according to this Consent and Waiver will be kept confidential by the school-based clinician. It will not be redisclosed to any other person, agency or organization, including ICSIC Commission agencies, without my additional consent in writing except, as noted above, for case consultation, supervision, and administrative purposes.

12) I understand that I am not required to consent to the disclosure of any information, to give permission to the school-based clinician working with the ICSIC Commission to assess or develop a case plan for me, or to accept any treatment. The specific types of information that I agree the clinician may obtain are listed at the end of this form. I also understand that I may discontinue involvement at any time.

13) I understand that this Consent and Waiver means that the agencies or individuals covered by this consent will release information to the school-based clinician based on their opinion that the information is relevant. As a result, my consent may not result in the release of all information maintained by an agency or individual

14) The school-based clinician working with the ICSIC Commission has reviewed this form with me, explained its purpose, answered any questions I had. I have also been offered the opportunity to have this form in another language or read

*Initials of Persons Signing the Consent & Waiver form:*_____

to me. The clinician has also informed me that I may choose a person to assist me with this Consent and Waiver form.

15) By signing this document, I confirm that I am eighteen years of age and the person who is the subject of this Consent and Waiver form.

_____
My signature My date of birth

Date:_____

_____
Name and signature of clinician explaining form

_____
Parent's/guardian's signature

Date:_____

_____
Name and signature of clinician explaining form

_____
Child's signature if 14 or older but less than 18

Date: _____

_____
Name and signature of clinician explaining form

_____
Parent's/guardian's signature

Date:_____

_____
Name and signature of clinician explaining form

_____
Child's signature if 14 or older but less than 18

Date: _____

_____
Name and signature of clinician explaining form

_____	_____
Signature of other adult in the household	Signature of other adult in the household
Date:_____	Date: _____
_____	_____
Name and signature of clinician explaining form	Name and signature of clinician explaining form

OTHER SOURCES OF INFORMATION

In addition to the member agencies of ICSIC Commission who will be providing information regarding me, I also consent to the release of information by the following agencies and individuals:

Name of Agency/Individual

Address/Telephone Number

My signature

Child's signature if 14 or older but less than 18

Date:_____

Witness: _____

Name of Agency/Individual

Address/Telephone Number

Parent's/guardian's signature

Child's signature if 14 or older but less than 18

Date: _____

Witness: _____

Name of Agency/Individual

Address/Telephone Number

Parent's/guardian's signature

Child's signature if 14 or older but less than 18

Date:_____

Witness: _____

Name of Agency/Individual

Address/Telephone Number

Parent's/guardian's signature

Child's signature if 14 or older but less than 18

Date: _____

Witness: _____

Name of Agency/Individual	Name of Agency/Individual
Address/Telephone Number	Address/Telephone Number
Other adult (over 18) in the household	Other adult (over 18) in the household
Date:	Date:
Witness:	Witness:

CONSUMER CONSENT TO DISCLOSURE OF ALCOHOLISM OR SUBSTANCE ABUSE TREATMENT INFORMATION (42 CFR Part 2)

As the person who is the subject of this assessment, I authorize release to the school-based clinician working with the ICSIC Commission the following alcoholism and substance abuse treatment information:

Name of Alcoholism or Substance Abuse Agency: _____

Type of Information	Release (yes/no)	Obtained (yes/no)
The type of chemical use or dependence, frequency of use, duration of use		
Information concerning the intake disposition/enrollment		
My plans for treatment (e.g. short and long term goals and planned services)		
My progress and degree of participation in any alcoholism or substance abuse treatment, including related services/activities, dates, and results of urinalysis ar other AOD/toxicology related tests		
Termination or completion of my treatment		

This information is provided for the purpose of allowing the school-based clinician working with the ICSIC Commission to:

_____Conduct an assessment

_____Develop and manage a treatment plan

_____Make referrals and coordinate services with other service and treatment providers

_____Develop and implement a discharge plan

_____Enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf.

I understand that the above information is protected by Federal Regulation 42 CFR, Part 2: "Confidentiality of Alcohol and Drug Abuse Patient Records" and can only be disclosed with my written consent unless otherwise provided for in the regulations. The duration of this authorization is one year, or the duration of the above Consent and Waiver, whichever is shorter. I understand that I may revoke this consent at any time by following the procedures outlined in the Consent and Waiver, above. I understand that the school-based clinician must treat the above-cited information as confidential and may share the information only as indicated in Section 10 of the Consent and Waiver.

_____ _____

My Signature (Date) Witness (Date)

TYPES OF INFORMATION THAT MAY BE OBTAINED BY THE CLINICIAN

Please Cross Out Any Type of Information You Do Not Want Disclosed to the Clinicians

Type of Information Obtained by the Clinician	Agency Providing the Information
This table will be completed once the appropriate information is provided by ICSIC members. At that point the Consent and Waiver will be available for administration by school-based clinicians	

ATTACHMENT B

Security Protocols for School-Based Clinicians, their supervisors, and designated Staff Engaged in Work (staff) with the Interagency Collaboration and Services Integration Commission (ICSIC)

Use and Storage of Confidential Information:

I. Paper files

a) Confidential information will be stored in locked filing cabinets within a centralized and locked storage room when not in use. All filing cabinets as well as doors to storage rooms will remain locked except when staff are accessing files.

b) Confidential files will be reviewed by authorized staff behind closed doors and will not be removed from the premises where they are normally stored.

c) Confidential files will not be left unattended at any time.

d) Unnecessary or duplicate paper copies will be destroyed using a cross-cutting paper shredder. All paper records will be destroyed on a regular basis, except those required for evaluation or research purposes or which must be maintained according to federal or state laws, rules, and regulations.

e) Staff will not transfer confidential information by fax.

II. Computer files

a) Access and storage
   1. Computerized information will be stored centrally within a secure office, the location of which will be determined by the ICSIC Commission.
   2. Only those ICSIC staff with a need for the information, as designated by the Chairman, will have access to the portion of the computer where confidential information is stored.
   3. Each school-based clinician will have access only to those cases assigned to him or her.
   4. Files that contain confidential data will by encrypted and password protected when not in use.
   5. Each individual and family will be assigned a non-identifying code; cases will be referred to by this code, rather than by name, whenever possible.

b) Workstation security

1. Each computer with access to the ICSIC database will have the following security measures:
    a. Hardware boot-up password protection.
    b. Staff specific passwords and permissions for entry and access to the computer network
    c. Password protected screen-saves will be automatically launched after a workstation has been left idle for 10 minutes.
    d. Virus protection software will be updated on a regular basis.
    e. Staff members will turn off their computers when not in use.

c) Network security
    1. Remote access to the computer network will be restricted to only those with access to confidential information.
    2. The ICSIC Commission will ensure that state of the art hardware firewall protection is used to protect the computer network from unauthorized access via the Internet.
    3. Access to the computer system will be by password identification only.

III. Phone conversations and meetings

a) Staff will conduct conversations regarding confidential information in private and not in front of those with no authorization to receive the information.

b) Participants in planning meetings will be only those included in the Consent and Waiver form.

IV. Transfer of information

a) When information cannot be transferred by means of a secure computer transfer, Staff will collect or provide information in person whenever possible and as soon as is practicable.

b) Staff will encrypt and password protect any files which are provided electronically.

c) Each program that supplies ICSIC with data will have a unique password, which will be restricted only to those individuals who are involved in the transfer of data.

Other ICSIC confidentiality policies:

I. Staff must become familiar with the confidentiality requirements incorporated in the Memorandum of Agreement Regarding Provision of Information, with the federal and state legal confidentiality requirements, and with the relevant professional standards regarding confidentiality.

II. Staff will be held individually responsible for abiding by the requirements delineated in the Memorandum of Agreement Regarding Provision of Information, with the federal and state

legal confidentiality requirements, and with the relevant professional standards regarding confidentiality. Failures to abide by such requirements and improper or unauthorized disclosures may be subject sanctions, including civil or criminal penalties.

III. In the event that confidential information is improperly disclosed, staff involved will take all possible steps to minimize the harm that might have occurred or may occur, including taking all possible measures to retrieve the information and to prevent any additional disclosure from occurring.

IV. No information will be provided for law enforcement purposes except under Court order. If the Commission receives a subpoena, court order or request for information under the Freedom of Information Act (FOIA), ICSIC will immediately notify the Office of Attorney General to review the request for information to determine whether the confidentiality provisions of the statute, policy and consent forms permit release and or whether the City should challenge or appeal any court order or subpoena purported to order the release of information in the possession of ICSIC.